Gender Specific Treatment for Clients with Co-Occurring Disorders
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Background

Approximately 10 million people in the U.S. have co-occurring addictive and mental disorders (SAMSHA, 1997). The most common term that has been used to identify treatment programs for persons with co-occurring disorders is "dual diagnosis", which most frequently is used to describe the presence of two co-occurring illnesses, substance abuse or dependence, and a severe and persistent clinical syndrome, such as major depression, bipolar disorder, or schizophrenia (Hills, 2000).

A study by Kesler et al., (1994) found that 52% of a representative national sample of community respondents with a history of alcohol disorders and 59% of those with a history of illicit drug disorders also had a history of at least one mental disorder. Such statistics have lead a number of experts to declare that clients with co-occurring disorders should be the "expectation not the exception" for treatment providers in the public substance abuse and mental health treatment systems.

For a number of reasons, the concentration of persons with mental health and substance use disorders in correctional settings (Abram, Teplin, 1991), has been found to be rising dramatically. A significant factor contributing to that growth is the large number of drug law violators. Given the increasing confluence of mentally ill and/or substance abusing individuals who are seen in courts and community settings, jails, and prisons, greater attention has been focused on the need for diversion and rehabilitation programs in those settings (American Bar Association, 1992; Dvoskin, 1991; Inciardi, 1992; Luekefeld & Tims, 1992; National Institute of Corrections, 1991; Steadman, 1991).

The heterogeneity of those with co-occurring addictive and mental disorders has only recently begun to be recognized, and treatment strategies for different segments of this population are being developed. As public health and mental health agencies are threatened by budget cuts, it is crucial that initial gains in acknowledging and addressing their needs not be lost or abandoned (Alexander, January 1996, a).

Gender Specific Treatment Response

In response to the identified needs, in September of 1998, the First Judicial Department of Correctional Services established a community-based treatment program within its correctional facility. The structured treatment program is designed to identify, educate, and treat those offenders under the supervision of the First Judicial District who suffer from co-occurring substance abuse/dependence and severe and chronic mental illness disorders. The Waterloo Residential Correctional Facility established a sixteen bed unit for

male clients. The overall goal of the Dual Diagnosis Offender Program is to enhance the potential of the client to be able to establish and live a law-abiding lifestyle with a stabilized mental condition, free of chemical dependency. Program objectives include diverting dually diagnosed clients from lengthy incarcerations in local and state institutions, as well as enhancing communication, coordination of services, and understanding of client needs between agencies involved in services with this population.

According to Hammett and Daughtery, (1990), women are typically underserved in correctional settings in all types of jail programming, even though, millions of women in America suffer from co-occurring substance abuse and mental health conditions (Center on Addiction and Substance Abuse, 1996). Admissions of persons with co-occurring disorders were more likely to be female than substance abuse only admissions. They were also more likely to be white and less likely to be in the labor force than substance abuse only admissions (The Dasis Report, April 4, 2002).

In addition, a substantial majority of women with co-existing condition have also experienced violence. Women who struggle to overcome these problems are likely to have more severe difficulties and use services more often than women with any one of these problems alone (Harris, M., 1994). Because services tend to be fragmented, and treatment philosophies can be inconsistent, these women face barriers to adequate care (Grella, C.E. 1996).

It became apparent to the staff at Correctional Services that many of the female clients served appeared to be suffering with co-occurring disorders. In response to that need, in January of 2003, the First Judicial Department of Correctional Services established a gender specific residential and community-based program for females who suffer with co-occurring diagnosis issues.

Delivery of Services In a Meaningful Manner

Best practice indicates that integration of treatment services maximizes intervention efforts aimed at addressing the specific symptoms and behavior patterns associated with the experience of both classes of disorder (Hills, 2000). Since integrated treatment focused on both disorders simultaneously, within the same service setting, is thought to be best practice, in 1998, Correctional Services partnered with a local mental health agency as well as a community substance abuse treatment program to address those issues. Contracting with Black Hawk-Grundy Mental Health Center and Pathways Behavioral Services created the ability for the “synergy that produces services well beyond the scope of what any single system could have hoped to mobilize on its own” (SAMSHA ,2001). Both providers have employees working directly out of the Correctional Services setting creating a confluence of services for the client. Clients are afforded intensive treatment within the correctional milieu by the treatment team which includes a Probation/Parole Officer, Mental Health Counselor, Substance Abuse Counselor, Residential Officer Supervisor, Program Supervisor, Continuing Care Probation/Parole Officer, and a Psychologist. The team participates in cross-training, which requires clinicians and programs, rather than clients, to make treatment compatible (Drake, et al., 1996).

Similarly, within the same service setting, in order to provide integration of treatment services designed to focus on both disorders simultaneously, the gender specific female program, an amalgamation of what has been learned by the process of providing integrated treatment, was initiated. Since, only recently, has attention been drawn to co-occurring illnesses issues among women, the process of treatment presentation recognized issues needing to be addressed included poverty, residential instability, social isolation associated with severe mental illness, and exposure to physical and sexual abuse (Alexander, 1996).

Program components that are important for women in both the addiction and psychiatric literature include adequate and early identification of associated problems, and a treatment philosophy based on competency-building and empowerment in safe, accessible, community based treatment (Abbot, 1994; Burman, 1994; Finkelstein, 1993; Hagan, Fennegan & Nelson-Zlupko, 1994; Harris, 1994; reed, 1987; Wilke, 1994).

The close association among co-occurring illnesses, victimization, and homelessness suggests that both

residential needs and victimization must be addressed in treating these women. Provision of safe space for women with abuse histories may range from physical privacy to accommodating unusual sleeping times and places in supported residences. Because women with co-occurring disorders are at risk for violence from a partner, they need to develop 'safe plans' that include strategies for resolving abuse. They should be aware of shelters for battered women that accept dually diagnosed women, and they should know how to obtain and used restraining orders and hot-lines (Hagan, Finnegan & Nelson-Zlupko, 1994). In addition, women with co-occurring disorders need to understand what abuse is, and how abuse affects their psychiatric symptoms, their addictive behaviors, and their living circumstances (Harris, 1994).

Funding streams and financial structures were modified to facilitate service coordination. The resources available to multiple systems are blended and/or shared to ensure that services are configured in a way that meets the individualized needs of clients rather than the needs of the system or providers offering care (Gains Center, Summer 2000). The Dual Diagnosis Offender Program is funded through Federal, State, and County funding. Ongoing communication with the local Central Point of Coordination providers continues to ensure best funding efforts with individualized clients.

Challenges in the Treatment and Supervision of Offenders with Co-Occurring Diagnosis

Most individuals with co-occurring disorders generally face poor prognosis for involvement in treatment. They tend to experience difficulty with compliance with medication recommendations, are more frequently hospitalized due to more frequent suicidal behaviors, and also tend to experience difficulties in overall relational and social functioning

Accurate assessment of co-existing disorders also presents difficult challenges due to residual effects of addictive substances that may mask or mimic psychiatric symptoms. Dually diagnosed individuals may present with acute psychiatric symptoms such as anxiety and depression that may interfere with traditional forms of substance abuse treatment, and more often require hospitalization or participation in intensive mental health services (Evans & Sullivan, 1990). Involvement and retention of offenders with co-occurring disorders in treatment is often difficult, due to rationalization and blaming others for their difficulties, distrust of service providers, and sudden changes in psychiatric symptoms (Peters & Hills, 1997).

This population is also thought to be at greater risk for relapse following release from custody (Weiss, 1992). Therefore, treatment tailoring through reassessment requires the consideration that offenders with two concurrent diagnosis may tend to experience the following difficulties:

- Defiance development depending on length of incarceration,
- Amount of time drug/alcohol free
- Evolution of their disorder

These circumstances require that the individual be regularly reassessed to determine what is working in their treatment efforts and what still requires significant intervention. Treatment tailoring acknowledges the varying levels of motivation, ambivalence and treatment readiness that individuals present with and conceptualizes current treatment needs accordingly (Hills, 2000).

It is recognized that poor prognosis for positive outcomes occurs in the following areas for this population (Hills 2000): engagement and involvement in treatment; compliance with medication; greater rates of hospitalization; more frequent suicidal behaviors; and difficulties in social functioning.

Therefore, the Dual Diagnosis Offender Program is working toward the following solutions to address these barriers:

- Enhance the potential of each individual to find a way to live in the world productively within a law-abiding lifestyle. Mental health would be stabilized, and the individual would be free of chemical dependency.
- Divert those individuals who would serve lengthy incarcerations in local jails or state institutions.

- Determine those who can best be assisted within a structured community-based treatment milieu.
- Dedvelop enhanced communication, coordination, and understanding among agencies and professionals to determine is imperative. This should facilitate the client's readiness to engage in establishing a vision.
- Within the treatment milieu the residential officers and the mental health provider work closely together to monitor to medication compliance. The client regularly sees a psychiatrist to modulate medication effects.
- Increase self-understanding and self-soothing behaviors, along with medication compliance and remaining clean and sober, which appear to be lessening hospitalizations, and to some degree, suicidal ideation.
- Create opportunities for positive interpersonal interactions.
- Increase sense of self-confidence and self-control.

What Should Effective Treatment Involve?
Program Components

A series of core principles have emerged to focus treatment providers on how to optimize treatment outcomes for offenders with co-occurring disorders. Treatment participants have to become invested in treatment, understand the need to continue their connection with treatment over time, and must be offered services that meet their needs. This can be achieved by focusing on the following concepts: treatment engagement; treatment continuity; treatment comprehensiveness; and continued treatment tailoring through reassessment (Hills, 2000).

Potential program participants are referred to and screened by the DDOP Psychologist to determine eligibility for program placement and county funding for rent maintenance, medication, and medical bills. Appropriate clients are then court-ordered to the program for one year or until maximum benefits are achieved. Clients may also be ordered to the program by the Board of Parole. The minimum treatment period is 180 days.

The high prevalence of physical and sexual victimization among women and the known sequelae of abuse and trauma make it important that women's experience of trauma be included in the assessment and treatment decisions (Friedman and Schnurr, 1995).

From the clinical and research literature, several key principles have recently emerged to guide the design of treatment programs for individuals with co-occurring disorders in the justice system (Hills,2000). They include the following:

Individualized Programming to Address Symptom Severity and Skill Deficits

Following screening, the client is placed on a waiting list and the client's history is reviewed with the treatment team in preparation for his/her entry into the program.

The multi-disciplinary treatment team should meet prior to development of an individualized treatment plan to review different perspectives regarding diagnosis, onset of disorders, and interactive effects of disorders. The proposed treatment plan is then discussed with the offender to incorporate their impressions and to receive comments and suggestions that are consistent with their own therapeutic goals (Hills, in press).

"Phased" Treatment Interventions with Graduated Intensity

Offenders with co-occurring disorders appear to achieve the greatest benefit from highly structured psycho-educational treatment approaches. Early phases include emphasis on orientation, assessment, development of treatment plan, motivation, engagement, and persuasion. Didactic Secondary phases focus more on coping skills, life skills, lifestyle change issues, and cognitive-behavioral interventions. Later phases may include mentor activities, vocational training, and linkage with community peer support and treatment group (Hills, in press).

Similar to other treatment programs designed to treat co-occurring illnesses, the Phases developed within the Dual Diagnosis Offender Program are designed to establish a long-term plan for treatment that meets the requirements of the legal system and promotes individual's understanding of the relationship between their co-occurring disorders and their criminal history (Hills 2000).

Individualized Service Plans

Individualized service plans arise out of intensive evaluations and interactive consultation with multi-disciplinary input. Conclusions generated from differing disciplinary perspectives must be reconciled so that a comprehensive, integrated treatment plan can be created. Decisions can then be made about the initial therapy goals. (Hills 2000).

Varied Treatment Approaches

Treatment approaches include motivational interviewing that is focused on prompt responses to difficulties in thinking, as well as changes in response due to withdrawal or incremental acclimation to psychotropic medication. Educational components focus upon understanding how major mental illnesses affect individuals and their family systems, including poor self-image that lead to tendencies to withdraw from social contacts, and to engage in dysfunctional behaviors, including controlling fantasies. (Peters & Hills, 1997).

During the initial thirty days the client is assessed by the treatment team. An extensive social history is completed by the mental health provider, which includes assessment of his current pyschopharmacological interventions. The substance abuse counselor is also meeting regularly with the client to address the client's current or recent pattern of alcohol or drug use and develop treatment goals. The probation officer completes a Level of Service Inventory Revised (LSI-R) to determine the client's dynamic and static risks and needs.

Treatment services should address individualized cognitive abilities as well as level of motivation, and be comprehensive and flexible (Hills, in press). Integrated, comprehensive approaches have evolved in the mental health sectors that, when disseminated into the treatment culture, should consider sexuality, relationship, victimization, depression, and empowerment will be necessary if assessment of and services for women with co-occurring illnesses are to address women's needs effectively (Alexander, 1996 b).

Many women with co-occurring conditions and trauma histories have not had constructive preparation for parenting (Harmer, Sanderson and Mertin, 1999). Growing up in families with a substance abusing or violent parent, or without consistent nurturing and discipline, they lack positive parenting role models. Because of their experiences as children, they may feel ambivalent about their own children, and unsure of their abilities as parents (Grella, 1996). The nature of their complicated histories suggest these women have needs for multidimensional support and treatment modifications (Morris and Schinke, 1990). Gender specific individual and group treatment address emotional attachment issues.

Treatment Delivery

Phase One begins when the client is oriented to the facility setting, structure, and expectations with a residential officer. The client also meets with the probation officer to begin initial orientation to the Dual Diagnosis Offender Program goals and expectations.

The Psychologist schedules a meeting with the client and the treatment team thirty days after the client has entered the program. The team and the client then create an integrated and individualized treatment plan. During this Orientation Phase the client also becomes involved in the daily group treatment schedule.

While an understanding of the interaction between the co-occurring disorders may be an initial focus of treatment, later interventions are likely to deal with complex interpersonal skills and vocational difficulties

(Peters & Hills, 1997).

The male specific program integrates the following agenda. The Orientation Phase is followed by two Treatment Phases, each lasting approximately 60 days. The client is able to move through these phases upon completion of self-directed goals based on the individualized treatment plan. The client takes the initiative to have each treatment provider sign off on a checklist agreeing that the client has met his specific goals. Treatment intensifies during the two treatment phases as patterned problematic behaviors become evident, so then hopefully, the client is able to gain understanding into his previous choices that have caused problems, and learn new behaviors. Focus on supportive relationships becomes critical.

There is an emerging consensus from the past twenty years of studies that treatment must focus on building cognitive and interpersonal skills. Treatment plans must address the individual's specific deficits (Hills, 2000).Therefore, the Dual Diagnosis Offender Program offers structured individual and group treatment provided by the treatment team. Group content includes cognitive behavioral treatment, and psycho-educational groups designed to create greater awareness of both substance abuse and mental health issues. Process/issue groups allow focus on immediate issues. Clients also participate in community awareness/recreation groups.

Clients are also involved in community services, including AA/NA meetings, GED courses, Vocational Rehabilitation Services, community service work, church activities, psychiatric, and medical appointments. The individualized treatment plan drives all services.

Available family/support persons are encouraged to participate in family therapy with the Psychologist, and are invited to family educational groups, which are provided periodically with team members. These groups are designed to provide support and education regarding issues surrounding co-occurring illnesses as well as community resources. Family members may also be referred to a weekly family group provided by Pathways Behavioral Services, which focuses on education and peer support.

For women with co-occurring disorders, treatment programs should be multidisciplinary, comprehensive, and coordinated to address the full range of needs as they progress toward and remain in recovery (Alexander, 1996 b). The attitude that recovery must come first and that women need their own space to recover and cannot concentrate on their recovery with children present reflects a lack of understanding of access issues, of maternal and child health issues, and of the fact that true recovery for a mother usually works only when it includes her children (Finkelstein, 1994).

Treatment Linkages

Since most sentenced offenders are eventually returned to the community, treatment planning must consider linkage issues, and post release planning must begin at the point of contact of any individual (Hills, 2000), the initial treatment plan includes short-term goals focused on stabilization and adjustment, but also with long-term goals that are planning for discharge and transition into the community. It is hoped that most short term goals are completed near transition so that when the client enters the Continuing Care Component, focus is upon maintaining a healthy lifestyle, which would include adequate housing, positive companions, support groups, etc.

Peters and Hills (1997) point out that the need for a broad range of services available over several years time offer the best hope for achieving symptom stabilization and early abstinence. Therefore, a grant was secured to hire a probation officer to oversee male client’s discharge and aftercare planning. The key activities of the Dually Diagnosed Continuing Care Project are to provide intensive supervision of the high risk/high need dually diagnosed clients as they transition into the community. The probation/parole officer participates in regular reviews of the clients progress through phases as the client nears transition and assists the client through supportive case management, which includes individual counseling, group treatment, and extensive partnering with community services. The clients are familiar with the transitional probation/parole officer since he conducts one of the treatment groups during their residential treatment program. This officer is well acquainted with local supporters of dually diagnosed clients. Working

closely with the entire team, this officer is able to bring transitional clients back in the facility via “respite beds” should the client relapse and/or demonstrate behaviors that suggest he needs structure to stabilize.

In 2003 a grant was secured to hire a female probation officer and a female mental health person to deal specifically and directly with high risk/high need dually diagnosed females.

Needs of women with co-occurring illnesses include physical health care, a recognition of their adult sexuality, preventive education regarding pregnancy and STD’s, and help in dealing with role loss, including their role as parents (Alexander, 1996 b). These needs are currently being addressed by a Human Sexuality and Relationships class that is provided by community resources, including Planned Parenthood, Public Health Resources, local police forces, and a private therapist, along with Correctional Services providers. Classes are gender specific. The mental health provider also addresses the above issues in daily group treatment.

Many women with co-occurring mental health and substance abuse disorders and histories of trauma are parents who value their roles as mothers and bring skills to the task (Women, Co-Occurring Disorders and Violence Study, SAMSHA). Historically, treatment for these women has neither considered the importance of women's roles as mothers nor included their children (WCODVS, SAMSHA). Treatment can be optimized by acknowledging their roles as parents and incorporating this reality into service design and delivery (WCODVA, SAMSHA). Skills are needed for even non-custodial parents to cope adequately with the complexities of their relationships to their children and to their caretakers within and outside of the foster care system (Alexander, 1996 b). True recovery for a mother usually works only when it involves her children (Finkelstein, 1994).

These issues are being addressed by the mental health provider both in individual and in group treatment. Clients will also be referred to community providers to specifically address increasing parenting skills, complexity of relationships to their children, and grief issues regarding losses in their parental role.

Treatment for women with co-occurring conditions and histories of violence is optimized when it:
focuses on a woman's strengths

- acknowledges a woman's role as a parent
- improves interactions between the parent and child
- provides comprehensive, coordinated services for a mother and her children (WCODVA, SAMSHA).

In general, this female co-occurring program is substantially based on the same format as the male program with the following differences:

- movement of client's from community to residential supervision is not time limited
- the same probation officer remains with the client during their duration of supervision
- benefits/entitlements are not lost due to a regimented time-limited residential placement

Outcomes/Continuing Care Project

For the first four fiscal years of data compiled for the male program, approximately 43 to 49 clients participated in treatment per year. During the year of 2001, 29 clients were discharged from the program. Of the total population of 45 served that year, 10 of the clients were removed from the program and 3 escaped, while16 were discharged successfully. Those successfully discharged served an average of 239 days. Those who escaped served an average of 43 days, and those who were removed were residents for approximately 116 days. It seems that those who were not well suited to the program knew that by the end of the orientation phase. Those who were removed had actually started treatment but were uncooperative for any number of reasons, including arrests for new criminal charges while in the program.

The data suggests that unsuccessful discharges may have been related to screening of clients with issues that this program is not capable of addressing adequately. For example, those who escaped or

were removed, in general, tended to have not engaged initially.

During the first five months of 2002, 61 clients have been served, 8 of which have escaped after an average of 84 days, and 9 were removed after an average of 89 days. This suggests that clients who may have not been appropriate for this program are generally out of the program in approximately three months. It also appears that as the screening process is refined to rule out clients whose needs may not be met by our program, those who are unsuccessfully leaving the program are becoming fewer. Also, those clients can then be redirected to facilities better suited to their needs.

Of the remaining 44 clients served in 2002, 27 clients were successfully discharged, serving an average of 197 days. Of those being successfully discharged, a greater percentage of them are able to work productively in the community at least part time.

Approximately twenty five women have participated in the women's program during these first five months. Statistical analysis of data is being compiled and will be added to this paper as data is generated.

A key component of the Dual Diagnosis Program consists of the Continuing Care Project, where the success rate of supervision of clients transitioned from a structured care setting into integrated and varied status supervision within the community is approximately 60%. Given the obstacles of this population, the success rate is above the norm.

Current Barriers

Confidentiality issues/Parallel treatment

While the barrier of providing services in multiple service settings is overcome with all treatment providers working out of the same office setting, this process often becomes complicated by service provider's reluctance to share information from their clinical records, most often, based on reasonably clinically-based concerns about the appropriate use of records (Peters, Hills 1997).

Even though licensing regulations have previously caused these contracted agencies to express concern regarding sharing client collateral information, communication gaps are narrowing. Each providing entity now includes their paperwork in a united file, has access to united e-mail, and is able to access the summary log, which is a detailed summary of the current activities of the clients on their unit. Each entity is also able to read the chronological compilation of services/interactions generated by Correctional Services, all of which has enhanced overall communication and updating of client progress.

Reliance on Publicly Funded, Community-based Services to Pay for Rent, Medication, and Psychiatric Appointments

Offenders with co-occurring disorders must often rely on these services as they lack the resources to pay for treatment. As a result, they must compete with other low-income individuals to receive adequate and timely service. As public dollars for community services have become more scarce, dual diagnosis treatment services have become more difficult to obtain (Peters, Hills, 1997).

While emergency clients are usually funded, the majority of others are placed on a waiting, list which includes a larger list of many needing funding within the community. Those placed on that waiting list initially were usually not funded during their treatment time within this treatment milieu. This is changing as financial providers become partners in treatment provision and with a view to treatment continuum. Funding for placement becomes crucial to pay for psychiatrist evaluations as well as cost for medications.

Additionally, clients who are placed in either dual diagnosis program immediately lose all benefits/entitlements upon entrance to the correctional facility for an extended placement. Also, the reapplication process for those services, which can now begin while the client is still in residence, continues to require an extended time frame to reinstate benefits upon the client's release to the

community, which directly threatens medication compliance and other pertinent treatment issues.

Sharing of financial resources between community entities continues to be an issue.

Limitations Imposed by Grants

Current grant regulations disallow the use of overnight furloughs while male clients are in the residential component of treatment. All treatment is funded by grant dollars. Therefore, when the client actually transitions to the community he has not been able to put into practice new healthy coping behaviors.

Current grant regulations also insist male clients remain within the treatment milieu for at least six months, while it is increasingly recognized that many of the same people are capable of and willing to be released in a reduced amount of time.

Lack of Current Gender Specific Research

The absence of research in women's health care is identified as a barrier to effective treatment of women with co-occurring disorders.

However, information and innovative treatment models are emerging from both the mental health and the addiction treatment sectors that raise the next level of questions: (Alexander, 1996 b)

- We need to know more about the rates of co-occurring disorders among women with severe mental illness, their profiles of substance use, and their service use patterns.
- We need to know more about the social networks of dually diagnosed women: To what degree to they support recovery or promote relapse?
- We need to know more about if women with severe psychiatric diagnosis experience violence differently from the women with a less serious psychiatric disability.
- We need to know more about how early and ongoing experiences of violence and abuse affect the course of treatment for both severe psychiatric disorders and co-occurring addictive disorders.
- With respect to services, we must ask to what degree existing models adequately address the broad range of services need of dually diagnosed women.

Solutions/Future Endeavors

Continued regular communication with treatment service providers will enhance individualized treatment presentation. Monthly meetings will continue to collaborate with the local central point of coordination persons to prioritize client needs and to explore options with statewide central point of coordination providers.

The treatment team will continue to research and consider possible solutions other communities have pursued and adopted to treat this population. We will continue to practice in gender specific treatment options.

Integrated treatment plans will continue to focus on client engagement and individualized goals. Publicly funded community based services will continue to be pursued. Gender specific treatment options will continue to be researched.

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